

A MODIFICATION OF THE EVACUATOR

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Most urologists are familiar with the history of the so-called bladder evacuator. The details of its inception and subsequent career make most fascinating literature. As these are usually included in the average urological text, even if in rather desultory fashion at times, they should be elementary. Probably few more laudatory words have ever been written of a single mechanical contribution to surgery than those penned by various authors regarding the original model created by Bigelow (1883). It will suffice to merely mention the designs and improvements made by Bigelow, Chismore, Thompson, Freyer, Young, McCarthy and undoubtedly others. All of these models have had considerable clinical trial and some of them are still in general use. In recent years probably the ingenious evacuators of Young and McCarthy have had the preponderance of popularity.

Keeping step with the rapid developments of modern urological technique, the evacuator no longer sees its usefulness limited to cystolithopaxy. Instead the latter seems to have assumed a minor rôle in its usefulness having been displaced by the need for rapid evacuation of resected portions of prostate, bladder tumor and even blood clots. In assuming this new rôle the evacuator is saving the transurethral surgeon invaluable operating and anesthetic time, plus an inestimable amount of tedious instrumentation.

It is with this new era of usefulness in mind that another and quite different model of the evacuator is now presented. It is hoped that this new design will lack none of the utilities of its predecessors and that in addition it may embody a few desirable modifications.

It will be noted from the accompanying photographs that the body of the instrument is a single piece of blown glass. The systolic and diastolic water pressures are provided by a standard, 3-ounce B-D rubber bulb. (The newer, extra heavy bulb of the same type may be substituted for the ultimate in suction.) Connection to the urethral instrument is made by a short length of rubber tubing plus a simple metal connector. The simplicity of its construction, its ease of manipulation and the facility with which it may be emptied, filled or sterilized should be quite obvious.

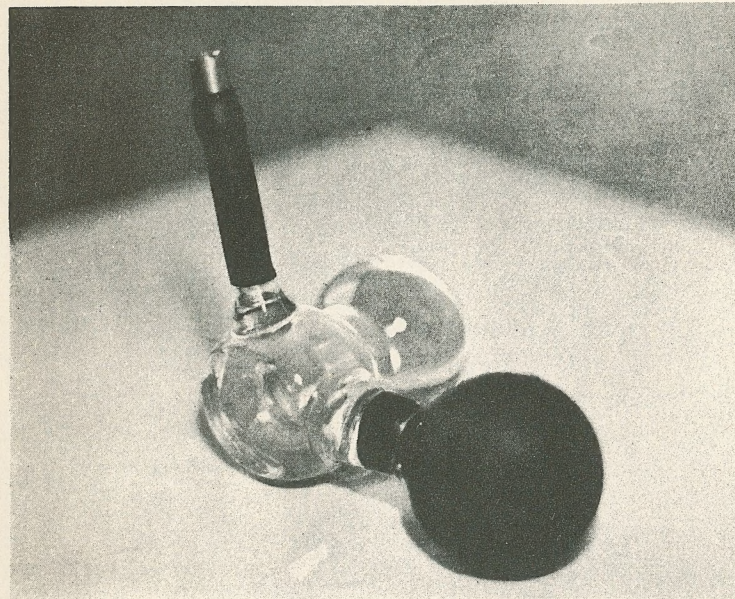


FIG. 1. Evacuator filled and in proper resting position ready for use



FIG. 2. Showing instrument connected to the resectoscope sheath

Its construction is such that it may be ordinarily manipulated with one hand, thereby permitting the operator to do his own evacuating and yet have the left hand entirely free. The connecting tip will fit the McCarthy Resectoscopes and the Brown-Buerger cystoscope sheaths. If desired this connecting tip may be removed and any other size or type quickly substituted to suit the operator. The principles of its action will be readily discernable from the accompanying photographs (figs. 1, 2 and 3). All air should be eliminated from the evacuator prior to its use and best results are usually obtained when the bladder is empty, or nearly

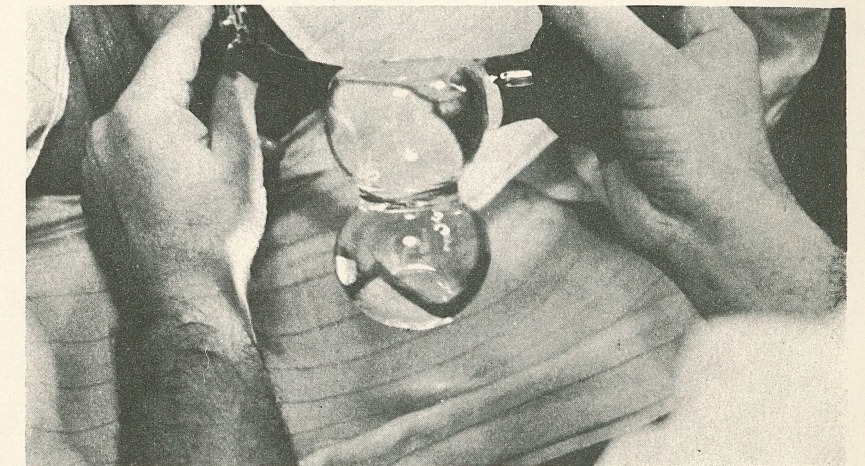


FIG. 3. Illustrating the usual working position. Systole ready to start

so, as systole begins. The maximum volume of fluid possible to force into the bladder never exceeds 3 ounces—the size of the bulb. Rather slow systole followed by quick diastole has proven the best procedure. A short wait after diastole, to permit the evacuated material to settle, is usually advisable. The cleared fluid above may then be used to repeat the process.

It is most convenient to have at least 2 or more evacuators ready for immediate use.

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